Department of Mental Health and Mental Retardation
Office of Deaf Services

Guidance on Hearing Status Codes and Their Application.

Purpose

Mandatory reporting of hearing status will begin on December 1st. This reporting will be in the demographic portion of the CARES system. The screen for this is now up and operational. The purpose of this guidance is to help admitting officers and staff so that they will be able to make determination as to which code to use.

There are three codes used to identify hearing status. These codes are functional, rather than medical, and can be determined fairly readily. They are listed below with some major points to keep in mind.

1. ***Hearing:*** *A person whose hearing is within normal range and exhibits no significant functional impairment of communication relative to hearing loss.*

    - The normal range for hearing is -20dB or better hearing. (A whisper usually is about 15 – 20 dB.) As a practical matter, you can check to see if a person can hear in the normal range by covering your mouth with something (paper, clip board, etc) or standing behind and out of lien of sight and asking a complex question in a whisper. If the patient answers appropriately then we consider that person functionally hearing.

    - A person who is functionally hearing, then will nor require any particular accommodation relative to hearing loss. Nothing further will need to be done beyond entering the appropriate code into the database.

2. ***Hard of Hearing:*** *A person with a hearing loss, either unilaterally or bi-laterally, who, with or without amplification, can understand spoken language in some settings.*

    - A person who has a hearing loss greater than -20 dB but less than -90dB falls into the generally accepted range for "hard of hearing." However, many people at the lower end of this range cannot hear speech as described above, which is why we prefer to use a functional designation rather than an audiometric one.

    - The fundamental thing we are looking for is whether the person relies ***primarily*** on hearing for communication. This does not mean able to hear everything, but rather that they depend on residual hearing for day to day interaction.

    - The presence of a hearing aid is a good indication that the person is at least hard of hearing, and possibility deaf.

    - A person who is hard of hearing and does not have an audiological workup should be referred to an audiologist to determine the exact level of the hearing loss. This determination would be the Axis III diagnosis.

    - ODS should be notified about this admission and a communication assessment may be warranted.

3. ***Deaf:*** *A person with a hearing loss who, with or without amplification, cannot understand spoken language.*

    - A person with a hearing loss greater than 90dB will, de facto, be deaf. However, many people with significantly less hearing loss than this rely totally on visual stimuli for communication. Occasionally, a person with a hearing loss in the upper part of this range is well habilitated to the use of a hearing aid and functions as a hard of hearing person in many settings. This becomes a judgment call. It is usually better

to err on the side of putting down deaf if you are not sure, since it will trigger more in-depth follow up from the Office of Deaf Services allow us to help you more.

It is important to note that the Department considers people who are deaf to be a part of a linguistic minority in addition to having an audiological disability. For this reason we treat these designations as a demographic feature, not a medical diagnosis.

Determination of Hearing Status

Determining hearing status for the purpose of our demographic information can be done using the decision tree in Figure 1, below. Several things need to be noted.

1. This decision tree is not a medical diagnosis. It is simply used to help admissions officers determine whether ODS needs to be consulted and what hearing status to enter. In some cases referral for a full audiological work-up will be needed in order to complete client information.

2. Hearing status may not necessarily be static. People with hearing loss may experience fluctuations that impact their functionality.

Decision Tree Discussion

1. Verbal Query

a. We will always start asking the person whether they are deaf or hard of hearing. Many people will "self-identify" but many will not. Either they don't realize they have a hearing loss or will be in denial. We want to ask first. Sometimes, especially in the case of people who attended a deaf program during school years (Such as the Alabama School for the Deaf,) their status will be obvious. Sometimes it will not be obvious. In any case, do not assume.

b. Ask the patient if they have a hearing loss or if they have trouble understanding people when they are talking.

i. If No – proceed to "Whisper Test"

ii. If Yes – proceed to Self-Identification

2. "Whisper Test"

a. A person with normal hearing can hear and understand a voice at 20 dB. (See page 4)

b. Stand behind the patient and whisper instruction for a two or three step task. Do not allow the person to see your face.

i. If pass, the patient is considered hearing and the test ends.

ii. If fail, there is a possibility of a hearing loss. Proceed to "Covered Mouth" Test.

3. Self Identification

a. If a consumer self-identifies as a Deaf person and signs, we honor that. We will treat the person as a signing Deaf person regardless of whether their audiogram shows them to be deaf or hard of hearing. A person who is hard of hearing may actually be deaf but doesn't want the label used. In this case, we will defer to their wishes in how we talk to them, but for the purposes of this screening, we will need to do further exploration.

b. Ask the person "Do you think you are deaf or hard of hearing?"

i. If Deaf, the screening ends and an interpreter should be called if on is not already present.

ii. If Hard of Hearing, go to the “Covered Mouth” test.

4. Covered Mouth Test

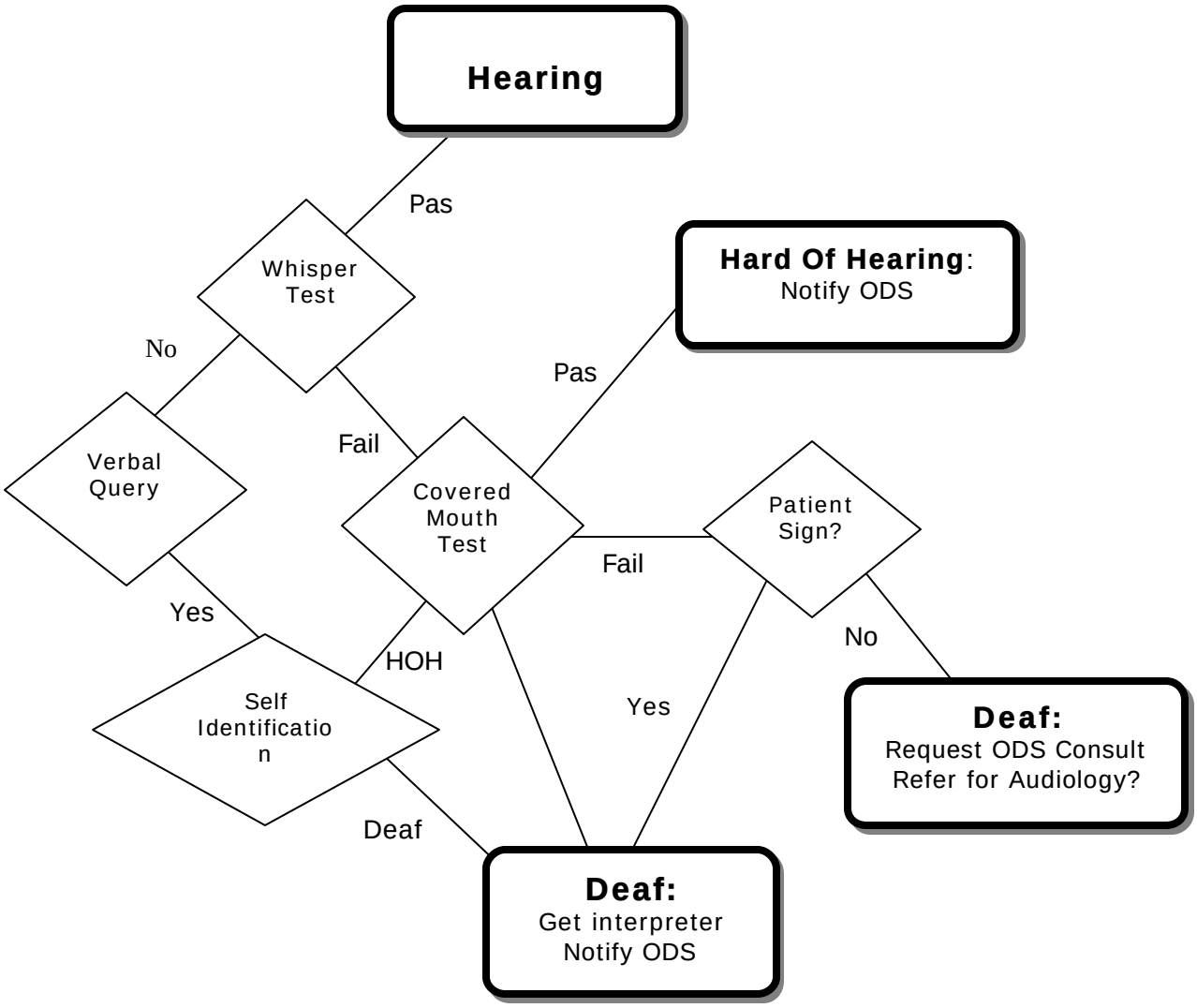
a. We want to see if they depend on residual hearing or “speech reading” for communication. People who are heard of hearing will still need some program modification, but those changes will be very different from a person who relies mostly on visual information. Additionally the modification will depend on the level of function.

b. Holding a piece of paper, clip board or standing behind the patient so that he or she cannot see you, give instructions for a two or three step task.

i. If pass, mark as hard of hearing, notify ODS for a consult on program modification if needed.

ii. If fail, ask if the patient knows Sign Language.

Figure 1: Sample Decision Tree for Determining Functional Hearing Loss



5. Does the Patient Sign?

a. Sometimes a patient who denies being deaf will still know Sign Language. This is important, because it gives us the most efficient channel for conveying information.

b. Ask, "Do you know Sign Language?"

i. If Yes, mark as deaf, notify ODS and secure and interpreter.

ii. If No, a communication assessment will be needed in order to determine the best method for meeting this patient's communication needs. Contact ODS to arrange this assessment.

This guidance does not cover every contingency. Please contact our office if you have any questions or special situations.

Figure 2: Relative Intensity of Familiar Sounds